State of Alaska
Neurodevelopmental and Autism Outreach Screening Clinic

This form can be completed by a parent and/or primary medical provider

Name of child: _____ Date of Birth: _____ Current age: _____

Parent(s) or Guardian(s) Name(s) _____

Phone: home:_____ daytime:_____ cell_____ Email:_____

Mailing Address _____City_____ Zip_____

Primary Health Care Provider (s)_____ Name of school/Preschool_____

Health Concerns	Yes	No	If previously evaluated for this – when and by whom?
Problems with growth			
Vision concerns			
Hearing concerns			
Sleep problems			
Chronic illnesses			
Neurological concerns			
Developmental Concerns	**Yes**	**No**	**Compared to other children his/her age**
Delays in learning skills			
Communication delays			
Motor delays			
Self-help delays (dressing, toileting)			
Problems with sharing			
Plays with other children often			
Engages in pretend or imaginative play			
Family history of developmental condition			
Behavioral Concerns	**Yes**	**No**	**Comments**
Temper tantrums often			
Aggressive towards self? Others?			
Activity level extremely high/low			
Poor attention control/distractible			
Shy/Withdrawn			
Happy most of the time			
Unusual fears or is routine bound			
Safety concerns/child fearless			
Rocking, spinning, or twirling often			
Cries often			

What services is your child receiving:

☐ Early Intervention ☐ Public health nursing ☐ OT ☐ PT ☐ Speech ☐ Mental hlth Tx ☐ Dietary
☐ Head start ☐ Spec Ed preschool ☐ Spec Ed classroom ☐ Has an IEP ☐ Other: _____

What do you hope to gain from this assessment (Pls use reverse side to expand on concerns)?

Who completed this form: _____ Date of Referral _____

***Fax this form* and additional supporting documents to**
Kris Green ♦ Specialty Clinics Coordinator/State of Alaska, DHSS
Kristine.green@alaska.gov ♦ Phone: (907)-269-3428 ♦ Fax: (907) 269-3465